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Good practice by Local Safeguarding Children Boards

The purpose of this report is to help Local Safeguarding Children Boards (LSCBs) to reflect on their practice, plan for improvements and learn from the experience of other boards. The report builds on and extends previous research into the functioning of LSCBs by analysing how boards are implementing improvements and assessing how they are beginning to develop methods to measure their impact.

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Executive summary

Local Safeguarding Children Boards are the key statutory mechanism for agreeing how the relevant organisations in each local area cooperate to safeguard and promote the welfare of children, with the purpose of holding each other to account and ensuring that safeguarding children remains high on the agenda across the partnership area.

In May 2011, the final report from the Munro Review of Child Protection, *A child-centred system*, was published. Within this report, Professor Munro set out the important role that Local Safeguarding Children Boards have in monitoring the effectiveness of partner agencies and recognised that they are key to improving multi-agency working, to support and enable partner organisations to adapt their practice and become more effective in safeguarding children.

Munro states that Local Safeguarding Children Boards are:

> '...well placed to identify emerging problems through learning from practice and to oversee efforts to improve services in response.' [1]

She strongly advocates a move away from a compliance culture to a learning culture and sees the Local Safeguarding Children Board as key to the development of a 'learning system'.

This report highlights elements of good practice in the operation of Local Safeguarding Children Boards. It aims to support the development of 'learning systems', by encouraging all Local Safeguarding Children Boards to reflect on their practice and plan for improvement.

This report shows that there is a lot of evidence of good practice in Local Safeguarding Children Boards. Many can demonstrate that they are learning from previous reviews and are paying particular attention to improving their practice in those areas which reviews found to be generally weaker across boards.

In the best examples, Local Safeguarding Children Boards have focused on a programme of initiatives, as part of a limited number of priorities, in order to respond to local development needs. These priorities are regularly reviewed and take account of learning from other boards and national research. They focus on strategic decisions and operational improvements, identifying areas for improvement using a combination of local knowledge, audit activity, national research and relevant data.

[1] *The Munro Review of Child Protection,* Department for Education, 2011; www.education.gov.uk/munroreview.

There remain issues with which even the best Local Safeguarding Children Boards are struggling. Many boards are beginning to make arrangements to demonstrate that their work impacts on outcomes for children and families, yet this is proving to be a difficult area for boards to evidence.

Board members and their Chairs spoken to as part of this survey, stressed the importance of becoming a 'learning board' to facilitate development and progress. Local Safeguarding Children Boards are encouraged to use the examples from this report and the questions which are set out at the end of each section as the basis for reviewing their progress and learning from the developments of other boards.

Section one: introduction

1. Local Safeguarding Children Boards (LSCBs) were established in April 2006 to place the responsibility for safeguarding and promoting the welfare of children on a statutory basis. They were charged with drawing all the relevant partner agencies together to work cooperatively to improve safeguarding outcomes for children and young people and to hold those agencies to account in respect of this work.

The purpose and scope of this report

2. The purpose of this report is to support LSCBs in reflecting on their practice, planning for improvement and learning from the experience of other boards. The report builds on and extends previous research into the functioning of LSCBs by presenting how some boards are implementing improvements and highlighting how they are beginning to develop methods to measure their impact.

3. The report is not intended to evaluate the overall effectiveness of individual LSCBs but to identify specific strengths of their operation. The good practice described in the report should not therefore be taken as an indication of Ofsted's assessment of those LSCBs which are cited. Ofsted visited a limited number of LSCBs to illustrate the good practice which is undoubtedly being undertaken in other parts of the country as well as in those areas which volunteered to take part in this survey.

4. The case studies and examples used throughout the report are examples of how some boards are facilitating improvements. They are illustrative and are intended to allow for reflection and to facilitate discussion about potential improvements among board members.

5. The report commences with an outline of the range of evidence used and a description of the relationship between LSCBs and Ofsted. Section two provides a brief overview of the policy context for LSCBs. Section three, the main part of the report, analyses how boards are demonstrating good practice within five

key areas which have been highlighted within Ofsted safeguarding inspections as important:

- governance arrangements
- quality assurance
- learning from serious case reviews and child deaths
- multi-agency training and learning
- measuring impact.

Evidence used in the report

6. The good practice set out in this report is based on evidence from a variety of sources:

   - Ofsted inspections of safeguarding and looked after children (SLAC) services
   - responses to requests to all LSCBs to submit examples of good practice in the five areas listed above
   - visits and in depth telephone interviews with those LSCBs which offered examples of good practice
   - a review of information about LSCBs and their practice which is in the public domain.

7. All previous Ofsted SLAC reports (2009–2011) were interrogated to find common themes in respect of the performance of LSCBs. These themes were further explored through visits and conversations with board members.

8. Ofsted received twelve submissions in response to a request for examples of good practice within LSCBs which would support the evidence highlighted through the SLAC reports. Nine of the LSCBs who submitted examples were visited for face-to-face meetings with board members and one was followed up by telephone interviews with a selection of board members. Due to difficulties of timing the other two areas were not visited.

9. A variety of professionals were spoken to as part of the survey including board managers, elected council members, auditors and independent Chairs. Board members and subgroup members spoken to included representatives from a range of services including children's social care, health providers, police, education and the voluntary sector as well as those responsible for data collection and interpretation.

The relationship between Ofsted and LSCBs

10. Ofsted has a number of different roles and responsibilities in relation to LSCBs. This diverse range of contact has contributed to its knowledge of existing good practice. There are three main roles.

- Since 2007, Ofsted has been responsible for evaluating the quality of serious case reviews (SCR) conducted by LSCBs and has produced a number of national reports on its findings. The SCRs make recommendations to the relevant agencies and look at lessons to be learned. LSCBs are expected to carry out serious case reviews when:
  - a child sustains a potentially life-threatening injury or serious and permanent impairment of physical and/or mental health and development through abuse or neglect
  - a child has been seriously harmed as a result of being subjected to sexual abuse
  - a parent has been murdered and a domestic homicide review is being initiated under the Domestic Violence Act 2004
  - a child has been seriously harmed following a violent assault perpetrated by another child or an adult
  - the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children. This includes inter-agency and/or inter-disciplinary working.
- Ofsted has a responsibility for carrying out inspections of safeguarding and looked after children (SLAC) services in local authority areas. These inspections include a specific evaluation of the effectiveness of the work of LSCBs, including the impact they have on improving outcomes for children and young people.[2]
- Ofsted has a regulatory role in relation to a number of settings, for example, early years, children's homes and childminders. Since LSCBs have responsibility for protecting children who are suffering or at risk of suffering maltreatment, they need to put in place processes for informing Ofsted about child protection concerns arising in any of these settings. A detailed protocol was published in April 2010, which sets out the relationship between Ofsted and LSCBs and specifically requires LSCBs to inform Ofsted of any unregistered childminding or childcare practice which comes to their attention.[3]

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[2] *Inspections of safeguarding and looked after children services: evaluation schedule and grade descriptions* (100174),Ofsted, 2010; www.ofsted.gov.uk/publications/100174.
Inspections of safeguarding and looked after children services: framework for inspection and guidance for local authorities and their partners (090027), Ofsted, 2010; www.ofsted.gov.uk/publications/090027.

[3] *Protocol between Ofsted and Local Safeguarding Children Boards* (070146), Ofsted, 2010, www.ofsted.gov.uk/publications/070146.

Section two: the policy context for LSCBs

11. In June 2010, the government announced a national review of child protection, to be led by Eileen Munro, Professor of Social Policy at the London School of Economics. Following interim reports in September and January, the final report *A child-centred system* was published in May 2011.[4] It contained a number of recommendations for LSCBs, all of which have been accepted by the government, and suggestions about strengthening their role.[5] The central argument of the review was about moving away from a focus on government targets and processes and towards a system which is centred around the individual needs of children and young people and whether they are being effectively helped.

12. Professor Munro clearly articulates the important role that LSCBs have in monitoring the effectiveness of partner agencies and recognises that they are key to improving multi-agency learning which will support and enable partner organisations to adapt their practice and become more effective, in other words become the 'learning systems' she describes.

13. A learning system is one which has an awareness of how its children's services operate and which regularly monitors, reviews and adapts its operations to become more effective. It is a system that uses theory and research to inform change and it is receptive to feedback from service users and practitioners. Feedback is used constructively to create an adaptive environment which allows for greater opportunities to exercise appropriate professional judgement. It relies on leaders to create an environment where the possibility of errors is expected and where errors are explored to ensure that adaptations are made, utilising what is learnt to make a difference to outcomes for children and young people.

14. LSCBs were established on 1 April 2006 under section 14 (1) of the Children Act 2004 and replaced Area Child Protection Committees (ACPCs). The Victoria Climbié inquiry report (January 2003) and other evidence highlighted concerns with, and variations in, ACPC effectiveness. The Joint Chief Inspectors' safeguarding review (2002) recommended that ACPCs should be established on a statutory basis to ensure adequate accountability, authority and funding.[6]

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[4] The *Munro Review of Child Protection – A child centred system: Final report,* Department for Education, 2011; www.education.gov.uk/munroreview.
[5] *A child-centred system The Government's response to the Munro review of child protection,* Department for Education, 2011; www.education.gov.uk/munroreview.
[6] *Safeguarding children: A joint Chief Inspector's report on arrangements to safeguard children*, Department of Health; 2002, www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103427.

15. The role of the new LSCBs was set out in statutory guidance[7] and regulations.[8] LSCBs are the key statutory mechanism for agreeing how the relevant organisations in each local area cooperate to safeguard and promote the welfare of children in that locality, and for ensuring the effectiveness of what they do. The core objectives of LSCBs are to:

- co-ordinate, monitor and support what is done by each person or body represented on the LSCB for the purposes of safeguarding and promoting the welfare of children in the area of the authority
- ensure the effectiveness of what is done by each such person or body for that purpose.

16. Safeguarding and promoting the welfare of children are defined as:

- protecting children from maltreatment
- preventing impairment of children's health or development
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
- enabling children to have optimum life chances and enter adulthood successfully.

17. LSCB functions, as set out in *Working together to safeguard children*, include:

- developing policies and procedures for safeguarding and promoting welfare
- communicating and raising awareness
- monitoring and evaluation
- participating in planning and commissioning services
- collecting and analysing information in relation to child deaths
- conducting serious case reviews.

18. Since their inception, the operation of LSCBs has been reviewed on a number of occasions and various measures introduced to improve their effectiveness. In 2008 the Joint Inspectors' Review of Safeguarding found that LSCBs were demonstrating greater independence in their chairing and reporting

[7] *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children,* HM Government, 2006. www.education.gov.uk/publications/standard/publicationDetail/Page1/WT2006.
[8] *The Local Safeguarding Children Boards Regulations 2006, Statutory Instrument 2006 No. 90*

arrangements and were beginning to focus on a wider safeguarding role in addition to child protection.[9] However, the report also highlighted that:

- Some statutory partners were not yet involved in the work of LSCBs in all areas, including Connexions services, the Children and Family Court Advisory and Support Service (Cafcass) and the Youth Offending Service.
- Few LSCBs were giving high priority to targeted activities to safeguard specific vulnerable groups such as looked after children, those in private fostering arrangements, asylum-seeking children in the community and in short-term holding centres and immigration removal centres, children in mental health settings, and children in secure settings, especially when placed outside their area.
- LSCBs were not yet in a position to demonstrate the impact of their work, since few had set themselves measures of their impact on safeguarding.

19. In his report *The protection of children in England: a progress report (2009)*, Lord Laming commented on the positive impact LSCBs were having on services for protecting children.[10] He also found that there was greater potential for LSCBs to drive improvements more effectively and called for the better sharing of local practice.[11]

20. In her recent report, Eileen Munro built on the work of previous reports and on current good practice. She gave her support to the strengthening of the role of LSCBs. This includes monitoring the effectiveness of help given to children and families, including early help. She also recommended the introduction of a systems approach to serious case reviews to enable the development of a 'learning system' in order to overcome obstacles to good practice.

21. The Munro review highlighted how important it is to develop quality assurance approaches, including more informal approaches such as case audits and peer reviews, which demonstrate impact on outcomes for children and young people. It emphasised the importance of the relationship between the LSCB and senior leaders in its partner agencies to ensure that local safeguarding practice is effective.

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[9] *Safeguarding children: the third joint chief inspectors' report on arrangements to safeguard children*, (080062), Ofsted, 2008; www.ofsted.gov.uk/publications/080062.

[10] *The protection of children in England: a progress report*, 2009; www.education.gov.uk/publications/standard/publicationDetail/Page1/HC%20330.

[11] *The evaluation of arrangements for effective operation of the new Local Safeguarding Children Boards in England - final report,* Department for education, 2010; www.education.gov.uk/search/results?q=DFE-RR027.

Section three: good practice in LSCBs

22. This section gives examples of good practice in LSCBs, looking at the evidence that Ofsted has gathered through inspections of safeguarding and looked after children's (SLAC) services which has identified clear themes for effective practice. Case studies illustrate how some boards are facilitating this good practice and enabling improvement in areas which previous reports highlighted as being generally weaker across LSCBs. The examples are illustrative and are designed to facilitate discussion, and for this purpose each sub-section is followed by a range of reflective questions for board members. These questions are also collated in Annex A.

23. Good practice is examined under five headings:

- governance arrangements
- quality assurance
- learning from serious case reviews
- multi-agency training and learning
- measuring impact.

Governance arrangements

Governance arrangements: Implications for practice

LSCBs demonstrate good practice by:

- keeping their governance arrangements under review using either national assessment tools or those developed locally
- recruiting Chairs with the relevant skills, who think and act strategically, and who are linked into local networks
- having Chairs who are willing to challenge and encourage others to do so
- recruiting board members who are sufficiently senior to hold others to account and effect change
- ensuring that board members, including lay members, are properly inducted and fully supported in their roles
- adopting a variety of measures to encourage consistent attendance at LSCB meetings
- experimenting with a variety of means for engaging with young people and frontline staff and acting on the results of this engagement
- establishing streamlined structures and ensuring that their groups and committees work effectively as a 'whole-system'

- concentrating on a limited number of priorities determined by national research and local circumstances
- widely publicising their business plans and regularly reviewing and updating them
- establishing effective working relationships with the local Children's Trust and defining their respective roles.

24. Previous reports found that, when they were first established, many LSCBs struggled to establish effective governance arrangements.[12] The accountability of LSCB Chairs was a particular issue for concern. However, many LSCBs, such as Bexley and Tameside, have now produced comprehensive handbooks, which include accountability and governance frameworks.

25. The *LSCB challenge and improvement tool*, developed by the former Department for Children, Schools and Families, has been used by LSCBs, such as Manchester, to identify areas for improvement in their governance arrangements.[13] Others, for example Tameside, have developed their own self-assessment tools, including independent peer review from a Chair of another LSCB. They are embarking on a 360 degree appraisal of the chair to improve accountability.

26. In terms of governance arrangements, good practice has been demonstrated in relation to:

    - leadership
    - partnership working
    - engaging with young people and frontline workers
    - structures
    - business planning
    - relationships between LSCBs and Children's Trusts.

Leadership

27. The majority of LSCBs have commissioned a Chair who is not employed by any of the partner agencies to bring a sense of independence and objectivity to the

[12] *The evaluation of arrangements for effective operation of the new Local Safeguarding Children Boards in England - final report,* Department for Education, 2010; www.education.gov.uk/publications/standard/publicationDetail/Page1/DFE-RR027.
[13] *Local Safeguarding Children Boards: the LSCB challenge and improvement tool*, DCSF, 2008; www.education.gov.uk/publications/standard/publicationDetail/Page1/DCSF-00581-2008.

board. This needs to be someone who has the experience, knowledge and credibility to hold the partner agencies to account. Ofsted inspection reports have found that independent LSCB Chairs are now making a significant difference:

> 'The Chair of NCSCB provides effective leadership and ensures that all agencies represented are fully engaged in the maintenance of effective safeguarding provision and processes.' (Nottingham)

> 'The ESSCB annual report clearly identifies safeguarding priorities, which are being taken forward by an effective, independent Chair who is promoting a focus on achieving good outcomes for children and young people in the work of the Board.' (East Sussex)

28. The Munro review endorsed this viewpoint, stating that having an independent Chair increased the likelihood that the LSCB will be in a position to challenge and scrutinise effectively the work of local partners in protecting children and young people from harm. Independent Chairs are identified as being particularly effective when they are sufficiently senior, strategic, linked into local networks and possessing good local knowledge:

> '[The SSCB] is effectively managed and well chaired by a strong and knowledgeable independent Chair.' (Suffolk)

> 'A well-respected Chair exercises effective leadership and provides appropriate challenge to the HCT.' (Halton)

29. Some LSCBs have reported that an independent Chair has proved critical in achieving progress, particularly when the Chair has been willing to challenge board members, has encouraged board members to challenge each other and has helped to create a climate of trust in which partners can be open with each other. For example, in Tameside, board members reported that the independent Chair ensured a focus on children and held the Chief Executive of the local authority to account over budgetary decisions which impacted on safeguarding.

30. The seniority of all board members has also been found to be important for ensuring that thinking and action are strategic:

> 'The LSCB health representatives are at an appropriate level of seniority to ensure an effective contribution to decision making both within the LSCB and their own organisations.' (Shropshire)

> 'The KSCB, Children's Trust and local partnerships provide highly visible leadership on all safeguarding matters.' (Knowsley)

31. To ensure that board members provide strong leadership, some LSCBs are placing an emphasis on recruitment and induction processes, and on ensuring that board members are well-briefed on their role:

> 'Members of the board are of sufficient seniority, clear about their roles and on joining the board all new members receive a pack of membership information.' (Shropshire)
>
> 'The MSCB is well attended and the responsibilities of partner agencies are clearly identified.' (Manchester)

32. In Milton Keynes the LSCB have produced an induction booklet for lay members, which provides them with advice, information and guidance on how to become effective members of the LSCB.[14]

> **Milton Keynes Safeguarding Children Board: lay members' induction booklet**
>
> The lay members' induction booklet produced by MKSCB provides information on child protection and safeguarding, the role of LSCBs, the role of lay members and how they are supported. A self-evaluation assessment at the end of the booklet prompts lay members to assess whether they have all the information, tools and assistance needed to fulfil their role on MKSCB.
>
> New lay members are 'buddied' with an experienced board member who meets with them shortly after their appointment to discuss the topics in the booklet, to check their understanding of the issues and to discuss support during the induction period. New lay members also meet with the MKSCB Chair after they have been serving on the board for six months to discuss their contribution and any future direction their role could take.

33. Halton LSCB have also introduced a planned induction processes for lay members of the board together with an appraisal system, which provides an opportunity for them to offer feedback about the operation of the LSCB.

Reflective Questions for board members:

- How does your Chair bring independence and challenge to board discussions?
- How does your Chair facilitate participation from all board members including lay members?
- How do agencies currently respond to challenge and how could this be improved?

[14] *The Apprenticeships, Skills, Children and Learning Act, 2009,* provides for the appointment of two representatives of the local community to each LSCB in England to enhance stronger public engagement in local child safety issues and challenge the LSCB on the accessibility by the public and children and young people of its plans and procedures.

Partnership working

34. Inspections have identified a number of LSCBs where participation by partner agencies is particularly good:

> 'The SSCB is well established with strong multi-agency participation from health and other agencies including the local youth offending institution and the voluntary sector.' (Suffolk)
>
> 'Local health providers are fully engaged with the TSCB and all the subgroups, with good attendance rates.' (Trafford)
>
> 'There is good engagement of partners in the ESSCB and with the Children's Trusts arrangements. Both bodies have sought to broaden membership to all relevant organisations and the significant contributions made by the voluntary sector, district council and the youth parliament bear testimony to this approach. As a result they are more closely aligned to the communities they serve and more able to fulfil their community leadership roles.' (East Sussex)

35. LSCBs have adopted a variety of measures to encourage meeting attendance and partner participation. In Harrow, attendance is closely monitored and if a member does not attend or sends apologies they are contacted to identify any ways in which they might be supported to enable them to attend the next meeting. In Halton, patterns of attendance are carefully analysed and discussions held with the Chair on how barriers to attendance might be addressed.

36. Inspection reports have indicated that consistency in attendance at LSCB meetings has encouraged good working relationships and improved joint working between partners.

> 'There is an effective and well established HSCB which provides good leadership on safeguarding matters with a mature culture of multi-agency working.' (Halton)

37. Board members and Chairs, spoken to as part of this survey, repeatedly identified good, consistent attendance at meetings by senior managers as a way of building up trust and confidence. This facilitated open and honest challenge of each other, which could be given, and accepted, in a constructive manner. They felt that this led to improvements in the way partners worked together and, as a result, improvements in outcomes for children and young people.

38. Effective LSCBs encourage joint working at all levels throughout the partnership. Partnership working at an operational level is crucial in terms of providing quality services which will impact on outcomes for children and young

people. Devon LSCB had facilitated the development of a Multi-Agency Safeguarding Hub (MASH) as an example of effective joint working. This was developed following the results of an early audit programme and was designed to improve safeguarding outcomes.

Devon Safeguarding Children Board: Multi-Agency Safeguarding Hub

The aims of the Multi-Agency Safeguarding Hub (MASH), which was rolled out across Devon between June 2010 and April 2011, are to improve the quality of information sharing and decision-making at the earliest opportunity and to reduce the potential risk to children and young people.

The MASH model consists of a multi-agency team who continue to be employed by individual agencies such as the police or health services, but who are co-located in one office to help build trust and understanding. This team, which has grown as the project has been rolled out, manages a 'sealed' intelligence hub which is governed by protocols on how and what information can be released.

MASH has a particular emphasis on engaging with general practitioners. There is now a high level of confidence amongst partners about MASH being a secure way of sharing information. Tangible outcomes were now being reported, such as an increase in early intervention as a result of better information being gathered through MASH.

The Devon Safeguarding Children Board has played a 'support and challenge' role as the model has been developed, holding partners to account for their respective contributions.

Reflective questions for board members:

- How are partners engaged throughout your board structure?
- How is partners' attendance at meetings monitored and facilitated?
- What improvements could be made to partners' engagement in delivering frontline practice and understanding local issues?
- How does the board challenge partners about their contribution to improvements in frontline practice?

Engagement with young people and frontline staff

39. In some areas particular efforts have been made to engage with young people. In Hammersmith and Fulham discussions between the Borough Youth Forum and LSCB identified the outcomes, progress and priorities arising from the

Children and Young People's Plan consultation that ended in March 2011. In Milton Keynes, the development of the LSCB annual conference was led by young people who contributed both to workshops and to feedback at the end of the conference. This has enabled the conference to focus on issues that matter to young people and has led to improved confidence for those involved. Tameside LSCB is working with a user participation group to access the views of children and young people. It has a multi-agency licence for 'Viewpoint', an online resource which allows young people to give feedback, and has recently convened a residential weekend with Tameside Youth Council to consult with them on awareness campaigns.

40. Some LSCBs are able to show how the involvement of children and young people has made a difference. In Reading, young people are invited to LSCB meetings to talk about what is important to them. This has helped to shape LSCB priorities, such as the continued attention given to bullying. At the close of each board meeting, time is taken to reflect on how the discussions and decisions made at the meeting will make a difference to children and young people.

41. In Sheffield, close working between members of one of the LSCB's subgroups and young people has led to changes to the way in which licensing regulations are enforced for the sale of alcohol and control of body piercing establishments. Young peoples' views were also taken into consideration in developing policies on e-safety issues in schools.

42. In 2008 Barking and Dagenham LSCB set up a Young People's Safety Group which acted as the shadow LSCB.

Barking and Dagenham Safeguarding Children Board: Young People's Safety Group

The Barking and Dagenham Young People's Safety Group contributes directly to the LSCB. It is made up of 11 to 18-year-olds and is chaired by a young care leaver. Thirty young people regularly attend its quarterly meetings to give their views and opinions on how safe they feel in the borough. Its core functions are to:

- provide a forum for young people to work in partnership through a joined-up approach
- improve co-ordination, liaison and information between the key partners working with young people around safety and safeguarding
- work towards the agreed overall aims of increasing and improving the level of safety in the borough
- provide an opportunity for all members to initiate matters and work together to develop projects to improve safety and safeguarding for young people in Barking and Dagenham

- provide a forum for raising issues and solving problems around safety and safeguarding including research and consultation
- increase good practice in safeguarding practices and approaches by sharing expertise, information and resources
- identify gaps and develop solutions around safety and safeguarding.

43. As well as engaging with children and young people, some LSCBs are making progress in engaging with frontline workers. In Halton, the LSCB and the Children's Trust jointly arranged an annual 'frontline event' for the workforce.

Halton Safeguarding Children Board: Engaging with frontline workers

Each year, the Children's Trust or the HSCB takes the lead in delivering an event designed to provide frontline workers with an opportunity to engage with the Trust or the board and to develop an understanding of their work. The board is very visible with members introducing themselves and explaining what they do.

Frontline workers are encouraged to suggest ways in which improvements can be made to support them in delivering high-quality services for children, young people and their families. At each event, there is an update on actions agreed in the previous years ('you said, we did').

Topics covered at frontline events included: the implications of the serious case review on Peter Connelly for frontline practice; the Common Assessment Framework; team around the family; and the findings of the Munro review.

Issues, suggestions and questions recorded during table-top discussions are reviewed after the event by event planners from the Trust and the board and relevant actions are identified.

Reflective questions for board members:

- How is your board engaging with children and young people and ensuring that the issues it considers are important to young people?
- Would any of the participation ideas above work in your area?
- Do you have any further ideas about how you could involve children and young people?

Business planning

44. National research shows that the more effective LSCBs are those that concentrate on a few clearly articulated priorities.[15] Inspectors have found that strong practice is seen where LSCBs continually review and update their priorities to meet changing needs and pressures:

> 'Safeguarding policy and procedures are regularly updated and reviewed, for example, new guidance and procedures have been completed on honour-based violence, trafficking and forced marriage.' (Suffolk)

45. Where business planning processes are good, inspectors found that they are leading to tangible improvements:

> 'The MSCB has effectively supported the improvement of the frontline child protection services through its business plan.' (Manchester)

46. In order for business planning processes to lead to improvements, the priorities need to be relevant to the local area, be based on local knowledge and have a clear alignment to overall annual reporting processes and future planning. In Tameside, for example, several actions within the business plan came directly from focus groups of frontline practitioners who were able to highlight where challenges needed addressing.

47. In West Berkshire, the LSCB has produced a business plan with three clear priorities, which were developed based on local knowledge and national research. A collaborative approach was used to produce the business plan and to identify the three priorities.

West Berkshire Safeguarding Children Board: Business planning

When developing its business plan WBSCB sought to ensure that the themes that were prioritised were relevant from a multi-agency perspective, were important local issues and would improve multi-agency working, a key theme in national serious case reviews.

A series of exercises was used with groups of LSCB members from both WBSCB and the Reading LSCB. Each participant was asked to provide three themes that were relevant to their agency based on their local knowledge and that were key safeguarding objectives. Participants were assigned to groups, where discussion took place to inform each group's final three choices.

[15] *Local Safeguarding Children Boards, a review of progress,* DCSF, 2008; www.education.gov.uk/publications/standard/publicationDetail/Page1/DCSF-00592-2007.

Following this, choices were displayed and rated. This resulted in agreement about the three themes: domestic abuse; alcohol use; and early intervention. It was recognised that, although the themes would be the same for both LSCBs, there would be different objectives and action plans for each LSCB based on local knowledge of how each issue impacted in the two areas. The plan was agreed to run from 2011 to 2014 with objectives being developed on an annual basis.

To ensure that frontline practitioners are aware of the business plan, the priorities, why the priorities are important and how they each contribute to improving the three themes, the WBSCB produced a leaflet about the work of the LSCB which, in conjunction with a newsletter promoting the launch of the business plan, aimed to raise awareness of the priorities. A poster was also developed, available for all agencies to highlight the WBSCB priorities and to promote the work of the board. Presentations have been given to school headteachers to publicise the three business plan themes. WBSCB is seeking to demonstrate the impact of the implementation of its business plan by using an outcomes-based accountability model promoted by national guidance, so that each action has at least one measure which details a direct impact on children and young people.[16] Some of the measures being used are proxy indicators.

48. Feedback and progress reports to partner agencies and practitioners are essential so that professionals can understand what has happened as a result of the enacting of business plan actions, where they have supported impact and where improvements have been made as a result. One way of doing this is through the annual report, which is made widely available, and can be used to demonstrate how the board is impacting on safeguarding outcomes for children and young people.

> 'The NCSCB Annual Report 2009/10 is outstanding, clearly documenting the issues and actions taken to safeguard children and families in the city.' (Nottingham)

Relationships between LSCBs and senior managers

49. Although, following the passage of legislation through parliament, Children's Trust arrangements will no longer be a statutory requirement, Ofsted inspectors have found that a clear and agreed definition of the relationship between the LSCB and the wider children's services partnerships is key to effective working:

[16] *Implementing outcomes-based accountability in children's services: an overview of the process and impact*, (LG Group Research Report), Chamberlain, Golden, and Walker, NFER, 2010; www.nfer.ac.uk/publications/OBA02.

> ‘The implementation of the governance protocol, which defines the respective roles of the two organisations, has taken into account recent changes to statutory guidance affecting Children’s Trusts announced by government. It ensures that arrangements for each body to challenge and hold the other to account for safeguarding matters are well established. The Children’s Trust Executive Board and the ESSCB are increasingly effective in ensuring resources are deployed effectively.’ (East Sussex)
>
> ‘…their relationship and responsibilities have been well examined and are clearly outlined, and are understood by members The priorities link well and there is good evidence of the SSCB helping to shape future Trust priorities.’ (Suffolk)
>
> ‘Governance arrangements between Swindon Safeguarding Board and the Children’s Trust are clearly defined. All partners understand their statutory duties to co-operate and discharge these duties well.’ (Swindon)

50. In Halton, the LSCB and the Children’s Trust have a formal protocol that ensures clear accountability and effective challenge between them. The relationship between the two partnerships has improved and they are working together to implement the action plan from the Ofsted inspection of safeguarding services.

51. The Munro review recognised the pending change in legislation and suggested that the proposed health and wellbeing boards may, in practice, be expected to fulfil a similar role to that of Children’s Trust Boards:

> ‘LSCBs play an extremely valuable role and will remain uniquely positioned within the local accountability architecture to monitor how professionals and services are working together to safeguard and promote the welfare of children. They are also well placed to identify emerging problems through learning from practice and to oversee efforts to improve services in response.’

52. In practice, whatever the future structural arrangements, Munro recognised the relationship between the LSCB and senior managers as critical. She recommended that the annual report, which boards currently present to the Children’s Trust, is in future presented to the Director of Children’s Services, Chief Executive and Leader of the Council. Following the passage of legislation it will also be presented to the local Police and Crime Commissioner, the Director of Public Health and the Chair of the Health and Wellbeing Board. Together, these are the key people who are able to keep safeguarding high on the agenda and influence service delivery. Therefore, the need for them to be aware of emerging local issues and priorities is key to ensuring that those services are effective and that outcomes for children and young people improve.

53. It is also crucial that these senior managers and leaders ensure that robust relationships are in place across the partnership as the emerging new systems grow and develop

Reflective questions for board members:

- Has your board focused on a few, really important priorities which could make a significant difference through joint agency working?
- How is local knowledge utilised to ensure that the priorities are relevant to your area?
- Are all agencies and their staff aware of the priorities and why they are important to improving outcomes for children and families?
- How do staff know how what they do is having an impact on the priority areas?
- How do you measure the impact of your business plan on outcomes for children and families?

Quality assurance

Quality assurance: Implications for practice

LSCBs demonstrate good practice by:

- having comprehensive and integrated systems in place, which allow them to scrutinise performance in key areas, at different levels and in geographical localities
- involving frontline workers in audit processes
- using independent audits and inspection findings to drive improvement
- employing a variety of techniques and taking a very thorough approach to auditing
- adopting a thematic and planned approach to auditing
- using the outcomes of audits to learn and improve practice
- assessing the impact of changes resulting from audit findings on children and young people and their families rather than confining their attention to changes in processes
- having a high level of internal challenge but also challenging other agencies and holding them to account
- scrutinising not only their own activities but also those of other bodies, including young offenders' institutions.

54. LSCBs have a key role in quality assuring safeguarding processes, both those of individual agencies and across agencies. Ofsted inspection reports emphasise the role of LSCBs in supervising quality assurance procedures.

> 'KSCB ensures audits for agencies, including all schools, are carried out on an annual basis, so that agencies can demonstrate they are meeting all safeguarding requirements and take any appropriate action to address shortcomings. This audit process is also applied consistently to all commissioned services. KSCB has developed a system of multi-agency audits of practice conducted on an annual basis with evidence. This is strengthening joint practice.' (Knowsley)

55. A comprehensive approach to quality assurance is illustrated by Tameside LSCB's approach.

Tameside Safeguarding Children Board: Comprehensive approach to quality assurance

In 2010, the TSCB adopted a comprehensive approach to quality assurance, called the 'TSCB Quality Assurance Approach (QAA)'. The QAA has been influenced by the Safeguarding Audit and Improvement Tool developed for the Welsh Assembly by Tony Morrison and Jan Horwath. The QAA approach has three dimensions:

Dimension 1 – single agency practice and arrangements for safeguarding. Member agencies complete an annual safeguarding audit covering eight areas (self-assessment/observation, user/carers views, workforce, case record audit, and so on) on which they receive feedback.

Dimension 2 – inter-agency practice and arrangements for safeguarding, which are examined using focus groups, performance monitoring reports and multi-agency case practice audit themes; and which are reported to a quality assurance and performance implementation group.

Dimension 3 – the role of the TSCB in ensuring effective practice and arrangements for safeguarding in Tameside. Themes and learning from dimensions 1 and 2 contribute to the board's self-assessment of progress.

The three dimensions influence the overall business planning and development of the Board as well as identifying areas for improving safeguarding practice and arrangements in Tameside.

56. Some LSCBs are now becoming much more proactive at involving frontline staff throughout their quality assurance processes:

'The HSCB have established multi-agency audit processes to which frontline staff across agencies have opportunities to contribute with learning taken back across and within agencies.' (Halton)

57. Since 2010, frontline staff in Southend have participated in LSCB multi-agency reviews of child protection processes alongside specialist safeguarding practitioners and managers. This has not only strengthened their audit teams, but has also provided valuable learning opportunities for the frontline staff involved. Re-audits show that they now have an increased understanding of child protection processes and there have been improvements in frontline practice as a result of this activity.

58. Some LSCBs are using multi-agency auditing to improve practice on a local area or locality basis. One such example is provided by Durham.

Durham Safeguarding Children Board: Performance Management Locality Groups

Performance Management Locality Groups (PMLGs) in Durham were set up in March 2007 and have continued to meet at least quarterly. Their aim is to address safeguarding issues within a prescribed geographical area of County Durham. Currently, there are three PMLGs which cover three distinct areas and include the entire county.

A focus on specific local issues has been generated through the collection and analysis of data which shows the performance of professional groups with a responsibility for safeguarding children. Children's services, health services, police and probation are represented on each of the locality groups. They produce action plans for their locality, which are reviewed and updated at each meeting.

The locality structures have been successful in engaging middle managers in discussing service improvements at the point of delivery. General practitioners who previously had little involvement with the work of the LSCB are now represented at meetings by a named GP. More recently, representatives from drug and alcohol services have started to attend meetings. This has helped to address issues of drug and alcohol misuse.

The LSCB Quality and Performance Manager presents local safeguarding data to each group and chairs each meeting. This means that learning from issues raised in one area is considered in other areas and the different locality groups are kept informed of county-wide initiatives. The PMLGs are also used as a forum for disseminating the findings of serious case reviews.

Data from each locality is collated on a quarterly basis and presented to the Durham Local Safeguarding Children Board by the LSCB Quality and Performance Manager. Issues emerging at a local level are passed on to the board in order to shape strategic priorities

Actions which have resulted from the collation and subsequent analysis of the locality data have included a coordinated approach to the production of chronologies; improvements to hospital discharge practice; and an increased number of reports by GPs for case conferences.

59. At Manchester LSCB, Ofsted inspectors found there had been good use of independent audits and inspection findings to drive local improvement. Elsewhere, a variety of techniques are used for auditing and quality assurance purposes. Good practice includes the establishment of multi-agency, or cross-authority, teams to contribute to self-evaluation reports. For example, in Wiltshire the LSCB work with the neighbouring Swindon LSCB to provide independence and challenge to their audit of organisations' responsibilities under section 11 of the Children Act 2004, which places a duty on key persons and bodies to make arrangements to ensure that, in discharging their functions, they have regard to the need to safeguard and promote the welfare of children.[17]

60. In Devon, and many other areas, a technique known as 'appreciative inquiry' has been used. This is a process that follows a similar methodology to a serious case review, but is used in cases which have gone well. In West Berkshire, each agency involved in the LSCB carries out 'spot audits', which are reported to the LSCB. Tameside uses inter-agency focus groups, facilitated by a Strategic Board member, to identify barriers to joint working. Those involved in multi-agency audits aim to be reflective in their approach and to ensure that learning from one audit is carried through to the next. Reading and Suffolk LSCBs provide examples of a thorough approach.

Reading and Suffolk Safeguarding Children Boards: In-depth auditing

In Reading, following scrutiny of available data it was identified that a very high number of referrals were being received by children's social care. The board commissioned the quality assurance subgroup to look at thresholds and a multi-agency audit took place involving 30 practitioners who brought cases to discuss where they felt thresholds had been inappropriately applied. Following the audit it appeared that thresholds were sound but issues were picked up around understanding, about the quality of referrals, not seeking consent from families and about incorrect

[17] *Statutory guidance on making arrangements under section 11 of the Children Act 2004*. DfES, 2007; www.education.gov.uk/publications/standard/publicationDetail/Page1/DFES-0036-2007.

use of the Emergency Duty Team (EDT) to make referrals. A short-term 'task and finish' group was instigated to look at referrals and over a six-month period they reviewed the whole process. A toolkit for practitioners was developed to help with the referral process. Following this exercise there have been two further audits of referrals – the findings of the first re-audit were that the quality of referrals had risen but consent was still an issue; the second time quality was better and the consent issue had improved. Referrals to EDT had dropped and there was a greater understanding of thresholds. The process for families being referred to social care is now more ordered, consistent and understandable for them. There is also greater engagement between agencies.

Suffolk LSCB undertook a review of effectiveness of safeguarding across the county to provide a baseline of evidence for its performance monitoring and quality assurance. The review involved all partner agencies and consisted of over 40 single agency audits/reports, two multi-agency audits and a peer review. Chief executives of all partner agencies were informed at the six-month and 12-month stages about the areas requiring further scrutiny by their agency.

61. When they were first introduced, multi-agency audits tended to be ad hoc and largely focussed on case reports, but they have now become more thematic:

> 'Performance and quality assurance arrangements within the SSCB are well established; a wide range of themed joint agency audits are presented to the board.' (Suffolk)

62. In Wiltshire, the LSCB had commissioned audits of processes relating to unborn babies, domestic violence and hearing the voice of the child. It was noted that there was a lack of evidence of the child's voice on many files. Following work in this area, a re-audit was undertaken which demonstrated that there had been a 100% improvement. Following this audit, Barnardo's have been commissioned to provide an advocacy service for all children over the age of five who are involved in the child protection process, to ensure that their voices are heard.

63. In Southend, as a result of findings from SCRs, multi-agency, targeted audits were undertaken of domestic abuse referrals to children's social care and of engagement with significant men in families. The audit of engaging with men demonstrated that this was not happening frequently enough. As a result training was introduced to ensure that practitioners were aware of the importance of engaging with men and the implications for improved outcomes for children. A follow-up audit has demonstrated a significant improvement.

64. Some LSCBs are adopting a planned approach to multi-agency audits. Both West Berkshire and Milton Keynes LSCBs have recently developed a strategic

quality assurance framework designed to monitor and challenge partner agencies on their contribution to the delivery of the three thematic priorities set out in their respective business plans.

65. Ofsted inspection reports have commended LSCBs which use the outcomes of audits to learn and improve practice. In Halton the monitoring of child protection services had led to concerns, such as gaps in the contributions by GPs, being identified, acted upon and improved. Inspectors found that the Knowsley LSCB was active in identifying any weaknesses in procedures or processes to safeguard children and had a good record of action.

66. LSCBs have provided information on how audit findings have also led to policy and procedural changes. In Durham, for example, notice times for those attending safeguarding conferences have been extended to allow them time to produce the necessary reports. In Tameside, audit findings have led to the production of a vulnerable young people policy for use by all local agencies. There have also been major partnership initiatives such as the following example in Devon.

Devon Safeguarding Children Board: Multi-agency case audits

Even before Lord Laming published his report identifying weaknesses in the way that agencies communicate and share relevant information, the DSCB commissioned an audit of a number of safeguarding files. There was evidence of information not being shared because of concerns about confidentiality and the requirements of data protection legislation, and also because of a lack of familiarity between agencies. The case audit coincided with work by the police to develop more robust systems for sharing information. Together these initiatives led to strategic discussions at LSCB meetings and, eventually, to the setting up of a Multi-Agency Safeguarding Hub (MASH).[18]

67. In some areas, monitoring and audits are used to input into the overall strategic analyses which are undertaken to assess how well the provision of services in an area is meeting its needs. Inspectors found that an annual report in Nottingham synthesised the issues emerging from audits and set out the actions taken to safeguard children.

68. LSCBs report that audits often result in the production of multi-agency action plans which are monitored at board level. These are sometimes supplemented by plans for single agencies which help to disseminate learning. Good practice also includes the merging of findings from multi-agency audits with the recommendations from local SCRs and national reports, in order to enable the LSCB to produce more complete action and improvement plans.

[18] See later discussion of the MASH initiative under the heading of Governance arrangements.

69. Some LSCBs are starting to place a greater emphasis on assessing the impact of changes put in place following audits on children and young people and their families. In Reading there are regular reviews of audits to examine the differences they have made for children, young people and their families. In Halton the LSCB's scrutiny and performance management subgroup focuses on identifying indicators that measure the impact of the LSCB on outcomes for young people rather than outputs. The subgroup has also worked with commissioned services to ensure a more outcome, rather than output, focused approach. For example, a service working with sexually exploited young people had initially identified the number of young people they would be working with during the year as an outcome for their service; in addition, they will now report to the board on the impact their service has had on these young people by looking at whether and/or how they continue to be involved in sexual exploitation.

Scrutiny and challenge

70. Where practice is good, inspectors have found that LSCBs have become an effective arena for inter-agency professional challenge:

> 'Trust Chairs and executive directors confirm that the level of professional challenge, both within the LSCB and internally at the Trust board meetings, and in governance and safeguarding children committees is good. The HSCB and health services hold each other to account in delivering serious case review action plans and the HSCB business plan.' (Hartlepool)

> 'The BSCB has ensured an appropriate focus on child protection within the wider safeguarding agenda and demonstrates good leadership and challenge in safeguarding matters with clear expectations of partners.' (Bristol)

71. In Sefton, the LSCB performance subgroup regularly challenges the performance of partners. Each agency in turn is invited to attend a meeting at which they are questioned by members of the subgroup taking on the role of 'critical friends'.

72. Challenge should be done on an inter-agency, internal board approach as well as external scrutiny by, for example, elected members. In some boards it happens in both arenas and LSCB members report high levels of satisfaction with this approach, which had resulted in evidenced improvements in safeguarding practice across a range of services. A high level of internal challenge is illustrated in Reading LSCB's approach.

Reading Safeguarding Children Board: Internal challenge

Prior to each board meeting all potential board reports are passed to the Reading LSCB quality assurance subgroup which checks each report for quality issues and then passes them on to the executive subgroup to draw up the agenda for each board meeting. The reports then go to the next full board meeting where they are sent out to all board members one week ahead of the meeting, and then discussed at the meeting.

Decisions are taken on recommendations made to the board and lead board members from relevant agencies are then nominated to ensure that the actions are carried out. These actions are then monitored by the performance and scrutiny subgroup on a quarterly basis.

Once a year, each organisation involved in the LSCB attends the performance and scrutiny subgroup to account for their delivery of LSCB priorities using data that they have collected during the year.

73. A number of LSCBs have extended their quality assurance arrangements to include external scrutiny of their functioning and impact.

> 'Effective and formal challenge and oversight are provided by members of the council's scrutiny committee who consider all board papers and reports, making representations and seeking further information when necessary.' (East Sussex)

74. Halton LSCB has found that its lay members have a particular eye for detail and have therefore involved them in scrutiny activities. Worcestershire LSCB has a combined audit and scrutiny committee. Southend LSCB has a dedicated scrutiny panel, providing external challenge to the board and ensuring it remains focused on pertinent local issues.

Southend Safeguarding Children Board: Scrutiny panel

The Southend LSCB scrutiny panel was set up in 2009 to scrutinise and challenge the work of Southend LSCB. It consists of elected council members from the local authority's Children and Lifelong Learning Scrutiny Committee and, since 2010, non-executive members of partner agency boards, including South East Essex Primary Care Trust and Essex Police Authority.

The use of the scrutiny panel enables input from strategic level and community level to be brought together. Local knowledge, through constituency representation, is fed into the board regularly through the scrutiny meetings and actions are followed up and reported on regularly.

Agendas are flexible and the panel has adopted an informal working style which enables its members to discuss with practitioners the reasons for their actions and recommendations. Members of the panel have shared their experience with other elected members to ensure that a wider range of members understand safeguarding issues.

Issues raised by the scrutiny panel are presented by the lead member for consideration by the SSCB. Members' local knowledge is also fed into board meetings. Progress on any actions agreed is monitored by the SSCB Executive.

In its two years of operation, members have used this scrutiny focus to gain a high level of knowledge about safeguarding and child protection procedures. As a result, the scrutiny of the board's efficacy has become sharper and better informed.

The panel has identified the role of school governing bodies as key to keeping children and young people safe. Examples of best practice have been disseminated and a template for governors' safeguarding monitoring visits produced. The panel also examined the potential impact on children of proposed changes in maternity and health visiting services. The panel was assured that there would be no loss of continuity in care but the scrutiny work also led to improved communication with the primary care trust.

Ongoing improvements in terms of frontline practice can be demonstrated through the cyclical multi-agency auditing process which is linked to issues raised strategically and locally as well as national issues.

The knowledge and effectiveness of the panel was noted by a peer review which took place in 2010.

75. Scrutiny of restraint techniques has been undertaken in those local areas where LSCBs have responsibility for Young Offender Institutes, including scrutiny of the policies and protocols which surround the use of restraint and the incidence of injuries.

> 'Good attention is paid to both to child protection and the broader safeguarding agenda. This includes consideration of the safeguarding arrangements for young people at the Warren Hill YOI.' (Suffolk)

76. Other LSCBs have been developing their practice in this area, including in Wigan.

Wigan Safeguarding Children Board: Oversight of secure setting

To embed the safeguarding of HM Youth Offender Institution (YOI) Hindley's young people in the business of WSCB, a subgroup was established with membership from the YOI and a wide range of Wigan agencies, including the Barnardo's independent advocacy service, the local Youth Offending Team (YOT), the Howard League and representatives from other local authorities who have young people held in Hindley's custody.

The subgroup set out a work plan which gave priority to a local audit of restraint and to consideration of the implementation of the recommendations from the national restraint review; enhancing understanding of safeguarding; and developing and implementing quality assurance mechanisms. The subgroup also looked at how complaints and induction processes were handled in the YOI and planned to carry out a review of whether young people at Hindley YOI are released to appropriate accommodation. Safeguarding recommendations resulting from the work of the subgroup are added to the WSCB action plan

Representatives from WSCB are security and key trained so that they are able to enter the establishment as and when required, thus are able to access all areas of the establishment and all young people independently. WSCB members receive quarterly reports on restraint used within the establishment and the subgroup has consulted all LSCBs in the North West on the scrutiny of Hindley.

Members of the WSCB regularly scrutinise full restraint records on a random basis, providing external scrutiny and challenge.

Reflective questions for board members:

- How are you using local knowledge, results from serious case reviews (both local and national) and national research to inform your audit programme?
- How are you acting on the results of audits to improve frontline practice?
- How are you measuring the impact of this work on ensuring that improvements are made to frontline practice?
- Do you regularly audit and re-audit to ensure continuous improvement?
- How does your audit activity link to strategic and future planning?

Learning from serious case reviews

Learning from serious case reviews: implications for practice

LSCBs demonstrate good practice by:

- being proactive in ensuring that lessons are learned from SCRs and in disseminating information from SCR findings
- ensuring that recommendations are implemented, holding agencies to account for progressing their individual action plans
- using SCR findings to drive improvement and to influence future plans
- learning from the process of carrying out SCRs
- understanding how implementing the findings of SCRs makes a difference to children, young people and their families
- learning from 'near misses' and serious incidents that do not meet the criteria for SCRs.

77. The *Working together to safeguard children guidance 2010,* requires LSCBs to undertake reviews of serious cases as outlined in paragraph 10 of this report.

78. Serious case reviews (SCRs) are undertaken so that agencies and individuals can learn lessons to improve the way in which they work, both individually and collectively, to safeguard and promote the welfare of children. Some LSCBs have been particularly proactive in ensuring that lessons are learned. This has been noted in a number of inspection reports:

> 'Findings from SCRs are well disseminated to staff across all agencies with very clear summaries of the key issues. There are good examples of improvements to services arising from SCRs, for example, domestic violence services. Action plans arising from audits, SCRs and management reviews are monitored well and the Chair is rigorous in holding agencies to account for progressing their individual action plans.' (Suffolk)

> 'A thorough approach is taken to ensure the sharing of lessons arising from serious case reviews and that the necessary changes to practice are secured, for example strengthening arrangements for pre-birth assessments, and followed up through audit and evaluation.' (Buckinghamshire)

> 'Findings from serious case reviews have been disseminated to staff and there are good examples of changes to practice as a result of learning from serious incidents. For example, rigorous systems are now in place for monitoring the provision for children who are in receipt of elective home

education, with appropriate and timely sharing of information if there are safeguarding concerns.' (Enfield)

79. LSCBs have adopted different methods for disseminating messages from SCRs. In Hampshire, the LSCB has taken a thematic approach, which includes the delivery of a training package to social workers. Other dissemination methods include workshops, road shows in different venues for frontline staff (including a recent road show organised by Norfolk LSCB outlining good practice lessons from serious case reviews to over 1000 public service workers), regular reporting to senior managers, newsletters and practitioner briefings.

80. Responsibility for dissemination of lessons learned from SCRs is often assigned by the LSCB to a serious case review group. However, in Halton, an executive board made up of a range of partner agencies undertakes the centralised dissemination of learning from SCRs. In some areas, the SCR group consider the learning not only from local SCRs but also from SCRs carried out in other areas. Where relevant, actions are identified, recommendations are made to the main board and improvements in practice are made. For example, in Reading revised guidance was issued to practitioners in relation to bruising on non-ambulant babies.

81. A variety of methods have been introduced by LSCBs to ensure that actions identified in SCR reports were fully implemented. Durham LSCB introduced a 'thematic tool'.

Durham Safeguarding Children Board: Serious case review thematic tool

Durham Safeguarding Children Board has developed a 'thematic tool' which enables the board to analyse actions taken across several reviews and to focus on 'hotspots' and themes that require attention in order to ensure that lessons are not only learned but continually acted upon to protect children.

The thematic tool provides:

- a master copy of completed and outstanding actions that assist analysis of repeated patterns; this has been used recently to highlight to the LSCB areas where there have been recurring recommendations over a period of years
- a thematic and systematic approach to reviewing actions
- improved accountability for learning by enabling senior managers to monitor outstanding actions
- an easy reference/log of actions to be carried out by those with responsibility for specific areas of development; for example, child protection procedures, training, and performance management.

The thematic tool is broken down into seven core areas covering the main areas raised by the majority of case reviews. These can be amended or added to in order to meet the needs of individual members of DSCB.

Outstanding actions are monitored on a three-monthly basis by the serious case review monitoring group. A month before the monitoring group meets, a copy of the thematic tool containing only outstanding actions is sent to senior officers in DSCB partner agencies with a copy to the named lead officer with responsibility to progress the actions. They are requested to review the progress on their actions and provide an electronic update using the template. DSCB's performance manager meets with each agency on a one-to-one basis to check on the implementation of SCR actions and to challenge agencies about the implementation of actions.

Information on progress is collated and presented to the monitoring group in advance of their meeting. After the meeting, completed actions are removed from the active tools and stored in a master copy.

The thematic tool has allowed DSCB to identify areas where the improvement has not been sustained and where a strategic response is required rather than actions by individual agencies. For example, repeated references to the training needs of GPs and paediatricians resulted in the production of specialist e-learning packages and a more detailed analysis of SCR recommendations identified information sharing as an ongoing issue. This resulted in the production of a comprehensive information sharing strategy.

82. Some LSCBs are seeking to ensure the effective implementation of SCR findings by engaging with all services that have a direct or indirect responsibility for the safety and well-being of children. For example, in response to the findings of a serious case review in Essex, the fire service have developed procedures for identifying households where fire hazards pose a risk to children.

83. Following learning from a serious case review by Liverpool LSCB, a bespoke, standalone safeguarding database was established at a general practice in Aintree Park. This provides a marker and information about every child and young person identified as being in need, subject to a child protection plan or where there are emerging safeguarding concerns. Information is updated contemporaneously during monthly case reviews, which include all GPs, the practice manager, receptionists, the advanced nurse practitioner and health visitors. Information is also shared with midwives and social workers. In Sheffield, an SCR led to the setting up of a safeguarding advisory service to provide advice on safeguarding issues for practitioners in universal services and other agencies. The advice is provided by a multi-agency, integrated team. The service is well advertised, has a high profile across Sheffield and receives a high

number of calls. Frontline health staff said that the advisory service provided good advice and support in response to safeguarding referrals to children's social care.

84. As well as ensuring the dissemination of learning from SCRs, some LSCBs have sought to learn from the process of carrying out the reviews. Following an SCR, Milton Keynes LSCB developed a serious case review toolkit, which provides relevant professionals with all the information they need to undertake a SCR. Training was provided to equip agencies to use the toolkit, including for practitioners from agencies such as Connexions, voluntary organisations and the Child and Adolescent Mental Health Service who had limited knowledge of the SCR procedures.

85. In Southend, internal auditors from the various LSCB partner bodies have applied their professional auditing skills to SCR processes. The internal auditors reviewed the entire SCR process including the action plans. They used their professional expertise to examine the evidence from each agency to ensure that actions could be demonstrated to have been completed, rather than relying on the word of the agency representative. Evidence was scrutinised using professional auditing approaches. The process has led to recommendations being made in terms of future SCRs, especially in relation to ensuring that actions and targets can be measured and can be evidenced.

86. Some LSCBs are seeking to measure the impact of changes introduced as the result of SCRs. In Reading the LSCB's quality assurance group included frontline practitioners in an audit to look at and discuss whether the implementation of SCR actions had made a difference to individual children and their families.

87. In addition to their responsibility for carrying out SCRs, LSCBs are required to put in place arrangements for a rapid response to unexpected child deaths and for reviewing the available information on all child deaths. They do this by establishing a Child Death Overview Panel (CDOP), many of which have been found by inspectors to be functioning well and to have instituted good practice.

> 'The Child Death Overview Panel is well attended by a wide range of professionals and analysis of deaths is leading to more targeted preventative work. Multi-agency public protection arrangements are robust and multi-agency risk assessment conferences are well established. Police contribute very strongly to partnership working and take a key role in a number of initiatives.' (Enfield)

> 'A Child Death Overview Panel is fully operational and provides an outstanding model for sensitively responding to and learning from the cases involved.' (Knowsley)

88. Suffolk's CDOP has extended its work to cover the local military bases and developed joint protocols with them. These enable concerns regarding children living on military bases and any child deaths to be appropriately investigated.

89. In Nottingham, both quarterly and annual CDOP reports are effectively scrutinised by the board, the primary care trust and the Children's Partnership Board. The action-log database is regularly reviewed and any slippage actively pursued. The findings from child death reviews have resulted in the compilation of comprehensive information on the availability of support from local bereavement support organisations.

90. Some LSCBs go beyond statutory requirements by reviewing and learning from other types of serious incidents.

> 'Good partnership working was promoted through piloting a review of a serious incident using the Social Care Institute for Excellence model. Staff were engaged well and found it to be a positive learning experience.' (Wirral)

> 'The LSCB has a standing serious case review panel and has effectively briefed partner agencies on the lessons learned from serious case reviews. It has also used the serious case review model to conduct rigorous management reviews for cases that did not meet the criteria for a full serious case review but from which there were lessons to learn.' (Wakefield)

91. Many boards are clearly attempting to ensure that the recommendations from serious case reviews are implemented and that lessons learned are disseminated and impact positively on practice. However, the current system for reviews has been criticised for encouraging a prescriptive approach, more focused on procedures and compliance than about understanding why professionals acted, or failed to act, as they did.

92. Ofsted, through its evaluations of serious case reviews, has found that

> 'serious case reviews were generally successful at identifying what had happened to the children concerned, but were less effective at addressing why.'[19]

93. The Munro review recognised the importance of using the SCR process to learn about professional practice. It recommended a move away from a process which looked at what went wrong to one which focused on a deeper

[19] *Learning Lessons, taking action: Ofsted's evaluations of serious case reviews 1 April 2007 to March 2008* (080112), Ofsted, 2008; www.ofsted.gov.uk/publications/080112.

understanding of why professionals had acted in the way they did. The report calls this approach a 'systems approach' which is similar in focus to the root cause analysis approach adopted by the NHS.[20]

> 'It provides a clear theoretical framework for understanding professional practice in context. The merit in the approach is that it counters the tendency of the current SCR methods to reinforce prescriptive approaches to practice, focusing instead on professional learning and increasing professional capacity and expertise.'

94. In 2008 the Social Care Institute for Excellence (SCIE) developed guidance[21] for utilising the systems approach to case reviews and some LSCBs have piloted this and are already noting an improvement in the focus on outcomes.[22] The SCIE model is focused on multi-agency professional practice rather than the particular child(ren) and family, identifying the deeper, underlying, issues which are affecting practice in an area. Changing these generic patterns contribute to improving practice more widely.

95. The Munro review suggests that a move from the current system will facilitate a change from a compliance to a learning culture. It also advocates the value in developing, as some boards are beginning to do, a wider repertoire of learning opportunities. For example, examining cases which fall below the criteria for a SCR, or putting those where there has been good practice under the spotlight in order to better understand the mechanisms underpinning effective help for families. Both of these approaches are seen to facilitate learning and are used by a number of boards to promote increased understanding within their areas.

96. In Medway, the LSCB reviews cases that do not meet the criteria for a serious case review as laid down in *Working Together*, but where there are nonetheless lessons to be learned about multi-agency working to safeguard children and promote their welfare. This includes incidents where a child has died of natural causes, but multi-agency working has been found to be a cause for concern. Medway LSCB has produced a guide for practitioners to explain the difference between SCRs and these 'lessons learned reviews' and to help practitioners prepare if they have to provide information for these reviews.

97. Westminster LSCB has used 'root cause analysis' to look at cases which do not meet the criteria for a SCR. Norfolk and Milton Keynes LSCBs also have a

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[20] *An organisation with a memory. report of an expert group on learning from adverse events in the NHS - chaired by the Chief Medical Officer*, Department of Health, 2000; www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4065083.
[21] *Learning together to safeguard children: developing a multi-agency systems approach for case reviews,* Fish, Munro and Bairstow, SCIE, 2008; www.scie.org.uk/publications/reports/report19pdf.
[22] *Briefing on the Munro review of child protection,* The London Safeguarding Children Board, 2011; www.londonscb.gov.uk.

'near-miss' review process to ensure lessons are learned where a case does not meet the SCR requirements, but where multi-agency learning is necessary. In Greenwich, the LSCB carried out a 'case of concern' evaluation of a case which didn't meet the SCR criteria, the lessons learned from which led to the improved recognition of the safeguarding of unborn and non-mobile babies.

Reflective questions for board members:

- How do you ensure that recommendations from SCRs are disseminated effectively?
- How do the results of SCRs feed into your audit programme?
- How do you ensure that any gaps identified in frontline practice as a result of SCRs are improved?
- Can you give specific examples of how you have learnt and changed practice following an SCR?

Multi-agency training and learning

Multi-agency training: Implications for practice

LSCBs demonstrate good practice by:

- striving to ensure the provision of a comprehensive programme of high-quality training linked to their priorities and business plans
- ensuring that training is quality assured and caters for the needs of a wide range of people, including volunteers
- using national research as well as local knowledge to shape training provision
- promoting the availability of training and adopting measure to increase its accessibility
- employing a range of delivery methods
- seeking to assess the impact of training not only at the time of delivery but at recurring intervals.

98. LSCBs are responsible for promoting the welfare of children by ensuring that there are appropriate training and learning opportunities for people who work in services that contribute to the safety and welfare of children. This responsibility covers both the training provided by individual agencies for their own staff, and multi-agency training for staff from different agencies to train together. It includes training and learning as a result of the child death review process and SCRs. LSCBs evaluate the quality of training provision and ensure that relevant staff undertake training which is appropriate to their role.

99. Research for the former DCSF and the Department of Health showed that multi-agency training is highly effective in helping professionals understand the respective roles, responsibilities and procedures of each agency involved in safeguarding children and in developing a shared understanding of assessment and decision-making practices.[23] Further, the opportunity to learn together is greatly valued; participants report increased confidence in working with colleagues from other agencies and experience increased mutual respect.

100. The Munro review recognised that LSCBs already play an important role in encouraging the provision of multi-agency training and reiterated the need for LSCBs to continue to make sure that such training is available and that participation is encouraged from across the partnership. It recommended that the board should assess the effectiveness of multi-agency training to safeguard and promote the welfare of children and young people.

101. Munro argues that the LSCB is key in developing a learning culture both within and between agencies; it needs to include people at all levels in organisations from frontline workers to the most senior managers. The review states: 'mechanisms for generating organisational learning are, therefore, valuable forms of multi-agency training'. The report stresses that this crucial role of LSCBs is further strengthened to facilitate deeper learning and understanding and improved training opportunities.

102. Ofsted inspection reports have highlighted LSCBs which provide high-quality training, including the following examples:

> 'Training and support for staff are consistently of a high quality, especially the multi-agency training arranged by TSCB for which take-up is good.' (Trafford)
>
> 'The LSCB has developed a comprehensive training programme which is closely aligned to its business plan. Social workers informed inspectors that the training they receive is valuable, relevant and comprehensive. Safer recruitment training has been rolled out across the partnership and there are clear indications from the increasing numbers of referrals that the role of the LADO (Local Authority Designated Officer) is understood.' (Ealing)
>
> 'The training delivered though the NCSCB is extensive and ensures staff in the partnership are well informed on all safeguarding matters.' (Nottingham)

[23] *The organisation, outcomes and costs of inter-agency training to safeguard and promote the welfare of children*, Carpenter et al, Department for Children, Schools and Families, 2009; www.education.gov.uk/publications/standard/publicationDetail/Page1/DCSF-RBX-09-13.

103. Whilst LSCBs have statutory requirements for ensuring that safeguarding training is taking place, some have gone further and taken responsibility for the planning, organisation and delivery of multi-disciplinary safeguarding training and events.

104. In good practice examples training strategies are clearly linked to the LSCB's priorities and to their business plans:

> 'The MSCB has developed a comprehensive training programme which is closely aligned to its business plan and staff across all agencies, including the voluntary and community sector, report that they have good access to high quality training.' (Manchester)

105. Effective training programmes are regularly updated in the light of new and emerging priorities. For example, when Durham LSCB decided to prioritise what they described as 'hidden harm' - the impact of drug and substance misuse and domestic violence - training courses were provided on relevant topics. Other high-profile LSCB initiatives are often underpinned by the provision of relevant training. In Warwickshire for example, the LSCB has provided training to enable its long-running 'taking care scheme' to be extended from primary schools to secondary schools.

Manchester Safeguarding Children Board: Multi-agency training and learning

Manchester Safeguarding Children Board highlighted the misuse of alcohol by parents and carers as an emerging priority within the city. It then undertook a multi-agency audit into practice in this field. The audit also took into account the views of parents and carers and, where practicable, children.

As a result of the audit, a practice tool is being developed for practitioners including practical tips for dealing with families where alcohol and substance misuse are issues. It also includes checklists and suggestions relating to multi-agency working in this area. Alongside the development of the toolkit, the existing multi-agency substance misuse and parenting training is being altered and extended to incorporate the learning from the audit and to include issues relating to the misuse of alcohol and substances by young people as well as parents and carers.

Manchester Safeguarding Children Board training is planned on an annual basis by the workforce development subgroup of the board and is informed by learning from SCRs; learning from multi-agency audits; local and national priorities, and incorporates elements of good practice. In this way training is about what works well and does not rely too heavily on a deficit model.

106. As well as responding to local need and aligning with emerging priorities, effective training is targeted at those practitioners who need it most. For example, in Southend it was identified through SCRs and other sources that there was a need to improve the recognition of safeguarding issues at the frontline. As a result of this, a common theme for 2011 has been developed across the partnership entitled *recognition, communication, response*. This is aimed at improving the knowledge of practitioners around safeguarding issues, how to respond to them, and how and when to communicate with other professionals. Training programmes have been identified to address this theme which are being targeted at the staff who will benefit the most from increasing their knowledge in this area (for example, 'bobbies on the beat', not police in the Child Abuse and Investigation Unit). Organisations are looking at what needs to change across the area and targeting those areas and people where a real difference will be made rather than organising a traditional conference, where staff who already have a wealth of safeguarding knowledge usually attend.

107. Some LSCB training programmes are also responsive to messages disseminated nationally. For example, Wiltshire LSCB ran a series of courses about domestic abuse, designed to meet local needs and responsive to Ofsted's report 'The voice of the child' which highlighted domestic violence as one of the issues commonly identified in serious case reviews.[24]

108. Some LSCBs have gradually extended the target audiences for their training programmes. In Berkshire, where three LSCBs delivered a joint training programme, volunteers as well as professionals were encouraged to attend relevant courses. Bristol LSCB has recently established safeguarding awareness courses for community dentists and Harrow LSCB has a rolling programme of training for members of their LSCB and its subgroups. In Southend, the LSCB organised a programme of training for council members, particularly those sitting on the children and lifelong learning scrutiny committee and their substitutes. This has had an impact on their ability to scrutinise the work of the board effectively as their knowledge of safeguarding issues has improved and their confidence to ask the right questions and feed in issues from their constituencies has grown.

109. Other LSCBs report good attendance at their training programmes, having experimented with a variety of means for increasing the uptake of training. For example, in Durham, many LSCB courses are delivered on an area basis to increase their relevance and accessibility and in Milton Keynes the LSCB produces a six-monthly newsletter to update people on training provision and remind them about courses coming up.

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[24] *The voice of the child: learning lessons from serious case reviews*, (100224) Ofsted, 2011; www.ofsted.gov.uk/publications/100224.

110. Much of the learning which takes place within LSCBs does not rely on traditional training involving people attending a central location at the same time. A range of delivery methods are used such as e-learning, disseminating lessons learned from serious case reviews, and audit results which are then discussed and acted upon within individual agencies.

111. For example, Wiltshire LSCB provides some of its core courses online; Wirral LSCB has produced a DVD to deliver training on safeguarding awareness and Hampshire LSCB runs a safeguarding children e-learning basic awareness course. In Manchester, messages are disseminated via area safeguarding fora which are chaired jointly by health providers and social care. Practitioners come together to discuss lessons learned from SCRs as well as good practice and reflect on how this can impact on multi-agency work in the area.

112. Wirral LSCB has a training committee which quality assures both single-agency and multi-agency training provision and sets standards to be achieved by course facilitators.

Wirral Safeguarding Children Board: Standards for course facilitators

The effectiveness of inter-agency training and development and its facilitation will be evaluated by the following performance indicators:

- all facilitators will have received 95% favourable evaluations from all inter-agency course participants
- single-agency managers will be able to identify via staff supervision that training courses have had a favourable impact on staff skills and knowledge back in their individual workplaces
- WSCB is satisfied that aims are being met and standards are being improved and maintained - evidenced by reports to the board from all agency managers and the Safeguarding Co-ordinator.

113. Inspectors have found that some LSCBs were making particular efforts to quality assure training sessions and to ensure that the provision is effective.

> 'A good range of training opportunities are available for staff with some evidence of impact, for example in raised awareness of the impact of domestic violence and child sexual exploitation. DSCB has developed more robust plans to evaluate the impact of training.' (Derby)

> 'The NSCB has recently revised its training arrangements and is implementing a new strategy with some evidence of impact especially in the voluntary and community sector.' (Norfolk)

114. In Milton Keynes, the impact of training is assessed not only at the time of delivery, but also after three months. Information from the impact assessments

is collated and passed to the training subgroup to shape future planning. In Manchester, when participants have completed a course they are given a certificate which has, on the reverse, the learning outcomes for the course and suggestions for discussions with their line manager in relation to how the participant can incorporate the learning outcomes into their day-to-day work.

115. In Rotherham designated health professionals have undertaken reviews and evaluations of training and, as a result, changes to provision have been made. For example, there is now improved access to training for GP practice staff, including practice managers, receptionists as well as GPs.

Reflective questions for board members:

- How does your training link to issues and gaps identified through monitoring, auditing and quality assurance activity?
- Are you clear about the benefits to be gained from multi-agency rather than single agency training and how do you make sure you realise those benefits?
- How is the impact of training measured?
- How does the training align with audit activity and gaps identified through this?
- How do you ensure that practice improves as a result of training activity?

Measuring impact

116. The Munro review argues for increasing the understanding of impact within LSCBs. It states:

> 'The complexity of the multi-agency child protection system heightens the need for continual and reliable feedback about how the system is performing. This is in order that organisations can learn about what is working well and identify emerging problems and so adapt accordingly.'

117. Munro is clear that improving outcomes for children and young people should be central to all service provision; organisations and partnerships should collect data intelligently to evidence the effectiveness of work undertaken to help and protect children and young people.

118. Board members and Chairs spoken to as part of this survey, were able to stress the importance of becoming a 'learning board' as important to facilitating development and progress. Hence, it is very important that they try to understand where the activity in which they are engaging is making a difference both to improvements in practice and to outcomes for children and families. Successful boards view feedback as essential and turn this into progress and improvement.

119. Some boards have been using the draft NDSU guidance from 2010 to move towards an outcomes based accountability model which advised that they should ask themselves three key questions:[25]

- How much are we doing?
- How well are we doing it?
- Is it making a difference?

120. Many boards have been able to demonstrate improvements on the first two points. However, some LSCBs are now beginning to develop methods of measuring the impact of what they do on outcomes for the children and families in their area, namely, the difference they are making.

121. The link between board activity and specific outcomes for children is not always an easy one to make as there are multiple factors involved. However, some boards are using measures which are beginning to demonstrate that they are having an impact. Sometimes the link is not a direct one, and the improvements in outcomes are implied rather than measurable. This is due, in part, to LSCBs being unable to track children over a long period (unlike research) and because, to a large extent, many of the outcomes are preventable ones, in other words things that have not happened; for example an injury to a child or a child death, criminal activity, teenage pregnancy or substance misuse. While boards are beginning to measure whether there has been a reduction in these activities, these are inevitably proxy measures and it is difficult to provide a direct link between the reduction and the activities of the board.

122. In some areas boards can now demonstrate that services provided are improving as a direct result of their activity. However, the extent to which they collate evidence of the impact of this improvement varies. For example, as a result of work on one of their identified priority areas, West Berkshire can evidence the improved attendance by substance misuse workers at relevant child protection conferences. Whilst not a direct measure, there is an implicit indication that decisions made at conferences will improve as a result of this input.

[25] Local Safeguarding Children Boards: Practice guidance for consultation, HM Government, March 2010; www.education.gov.uk/publications/standard/publicationDetail/Page1/DCSF-00312-2010.

Devon Safeguarding Children Board: Demonstrating impact

Devon Safeguarding Children Board ensures that local intelligence and information sharing has led to a good understanding by the board of the challenges and issues within the county and areas they want to focus on. Their specific focus on engaging with GP colleagues resulted in clear guidelines for GPs about information sharing to build confidence in the system. An awareness of the low engagement of GPs in child protection conferences, and the submission of reports to conferences, led to the designated lead developing a new template for reports. Along with clearer commissioning this has secured an improvement in GP engagement in the child protection process through the submission of more reports.

The implicit understanding of improvement here is that it is expected that decision-making at conferences will have improved because of the increased engagement of GPs.

123. Another improvement made as a result of board activity in West Berkshire was the appointment of tier-two mental health workers to work with children who fall below the threshold for Child and Adolescent Mental Health Services (CAMHS). The impact of this can be measured in terms of numbers of children receiving an appropriate service and an increased understanding of thresholds resulting in the CAMHS service not being overwhelmed by inappropriate referrals.

124. Devon LSCB routinely looks at previous recommendations from multi-agency case audits, and from national SCRs, in order to assess the impact. An example is in the improvement of record keeping by public health nurses following training. Again, the improvement in outcomes is implicit in the knowledge that poor record keeping has often contributed to poor outcomes and, therefore, an improvement in practice in this area should lead to improved outcomes.

125. Sometimes boards are able to go a step further and identify individual cases where improvements have been made, although this information is rarely collated. In Wiltshire, following an LSCB multi-agency audit which demonstrated that children were not well engaged in the child protection process, Barnardo's were commissioned to provide an advocacy service for children and young people over five years old within the child protection system. At the LSCB annual conference, Barnardo's gave a presentation detailing how individual children's lives had been transformed as a result of this activity, thereby demonstrating to the board that they were having a measurable impact on the outcomes for this cohort of children.

126. Some boards use the results of national research to influence their work and to assess the impact of what they are doing. This is used in conjunction with local knowledge about important priority areas of work. Improvements to professional practice are often used as a proxy indicator for improved outcomes

for children when previous national research has demonstrated a link between practice and impact on outcomes. For example, in Southend an issue was identified in relation to the involvement of men in the assessment process. Ofsted reports on serious case reviews have highlighted lessons learnt by other Local Safeguarding Children Boards about failings that resulted from not involving men in assessments of families.[26] Following Southend's audit, training and development was undertaken and a re-audit demonstrated improvements in the frequency of involvement by men. The inference is that as practice in this area is improving, overall outcomes for children will be improved.

Reflective questions for board members:

- How is your board measuring the impact of its activity on outcomes for children and young people?
- How can national research be used to inform improvements at the frontline?
- How can you strengthen links within your board between identified gaps, lessons from SCRs, auditing activity, training, future planning and improvements in frontline practice?

Section four: conclusion

127. LSCBs are able to evidence good practice in a variety of different areas of their responsibility. Many are able to demonstrate that they are learning from previous reviews of LSCBs and are paying particular attention to developing and improving their practice in relation to areas which those reviews found to be generally weaker across boards. These include:

    - governance arrangements, especially in relation to continuity of board membership, lay member involvement and the relationships between LSCBs and senior managers
    - the quality assurance role of LSCBs, particularly in respect of multi-agency auditing, internal and external challenge
    - the engagement of children, young people and their families in the work of LSCBs and in determining their priorities
    - the involvement across the structure of relevant partner organisations.

[26] *The voice of the child: learning lessons from serious case reviews* (100224), Ofsted, 2011; www.ofsted.gov.uk/publications/100224.

128. Board members and Chairs spoken to as part of this survey were able to stress the importance of becoming a 'learning board' as important to facilitating development and progress.

129. In the best examples LSCBs have focused on a programme of initiatives as part of a limited number of priorities in order to respond to local development needs. These priorities are regularly reviewed and take account of learning from other LSCBs and national research.

130. When particularly effective, good practice encompasses both a focus on strategic decisions and operational improvements, identifying areas for improvement using a combination of local knowledge, audit activity, national research and relevant data.

131. The examples in this report are intended to contribute to this learning through the dissemination of good practice. There is evidence that this kind of exchange already takes place between some neighbouring LSCBs, on a regional basis or as the result of national reports of lessons from serious case reviews.

132. LSCBs are encouraged to use the examples from this report, and the questions which are set out in Annex A, as the basis for review their progress and learn from the developments of other boards. The questions are designed to encourage thinking about what works in different areas. Some of the examples cited above may be adaptable to different areas, but others may be less adaptable and so the questions are here to encourage LSCB board members, staff and partners to reflect on how improvements can be made which are relevant to different areas.

Annex A: Reflective questions for consideration by Local Safeguarding Children Boards

Governance

- How does your Chair bring independence and challenge to board discussions?
- How does your Chair facilitate participation from all board members, including lay members?
- How do agencies currently respond to challenge and how could this be improved?

Partnership working

- How are partners engaged throughout your board structure?
- How is partners' attendance at meetings monitored and facilitated?
- What improvements could be made to partners' engagement in delivering frontline practice and understanding local issues?
- How does the board challenge partners about their contribution to improvements in frontline practice?

Engagement with young people

- How is your board engaging with children and young people and ensuring that the issues it considers are important to young people?
- Would any of the participation ideas above work in your area?
- Do you have any further ideas about how you could involve children and young people?

Business planning and relationship between LSCBs and Children's Trusts

- Has your board focused on a few, really important priorities which could make a significant difference through joint agency working?
- How is local knowledge utilised to ensure that the priorities are relevant to your area?
- Are all agencies and their staff aware of the priorities and why they are important for improving outcomes for children and families?
- How do staff know how what they do is having an impact on the priority areas?

- How do you measure the impact of your business plan on outcomes for children and families?

Quality Assurance

- How are you using local knowledge, results from serious case reviews (both local and national) and national research to inform your audit programme?
- How are you acting on the results of audits to improve and challenge frontline practice?
- How are you measuring the impact of this work on ensuring that improvements are made to frontline practice?
- Do you regularly audit and re-audit to ensure continuous improvement?
- How does your audit activity link to strategic and future planning?

Learning from serious case reviews

- How do you ensure that recommendations from SCRs are disseminated effectively?
- How do the results of SCRs feed into your audit programme?
- How do you ensure that any gaps identified in frontline practice as a result of SCRs are improved?
- Can you give specific examples of how you have learnt and changed practice following an SCR?

Multi-agency training and learning

- How does your training link to issues and gaps identified through monitoring, auditing and quality assurance activity?
- Are you clear about the benefits to be gained from multi-agency rather than single agency training and how do you make sure you realise those benefits?
- How is the impact of training measured?
- How does the training align with audit activity and gaps identified through this?
- How do you ensure that practice improves as a result of training activity?

Measuring impact

- How is your board measuring the impact of its activity on outcomes for children and young people?
- How do you use national research to lead to improvements in direct work with children and their families?

- How can you strengthen links within your board between identified gaps, lessons from SCRs, auditing activity, training, future planning and improvements in frontline practice?

Annex B: List of LSCBs visited

- Devon
- Durham
- Halton
- Milton Keynes
- Reading
- Southend
- Tameside
- West Berkshire
- Wigan
- Wiltshire

Submissions were also received from:

- Warwickshire
- Wirral